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1	Graham Bernstein 3525 Del Mar Heights Road #253	FILED
2	San Diego, CA 92130 Phone: 858-627-0064	2012 HAR 26 AM 10: 01
3	Fax: 858-627-0065	TO THE TRUE TO STRICT COURT
4		SOUTHERN DISTRICT OF CALIFORNIA
5		BYDEPUTY
6	GRAHAM BERNSTEIN, IN PRO PER	
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11	UNITED STATES DICTRICT C	OURT
12	SOUTHERN DISTRICT OF CALI	FORNIA
13	Graham Bernstein, an individual,	Case No. 12 CV 07 17 AJB JMA
14	VS	COMPLAINT FOR MONEY DAMAGES PURSUANT TO 29 U.S.C. 502 (a) and 1004
15	HEALTHNET LIFE INSURANCE COMPANY	et. seq. (Employee Retirement Income
16		Security Act of 1774, as amended).
	and Does 1-10 Inclusive Defendants	1 Falsa Protonges and Falsa Penrasantations
17	and Does 1-10 Inclusive Defendants	 False Pretenses and False Representations Breach of Contract/Fiduciary Duties
17	and Does 1-10 Inclusive Defendants	
	and Does 1-10 Inclusive Defendants	
18	and Does 1-10 Inclusive Defendants	
18	and Does 1-10 Inclusive Defendants	
18	and Does 1-10 Inclusive Defendants Plaintiff Graham Bernstein, alleges as follows	2. Breach of Contract/Fiduciary Duties
18 19 20 22		2. Breach of Contract/Fiduciary Duties
18 19 20 22 23	Plaintiff Graham Bernstein, alleges as follow NATURE OF THE ACTION	2. Breach of Contract/Fiduciary Duties
18 19 20 22 23 24	Plaintiff Graham Bernstein, alleges as follow NATURE OF THE ACTION	2. Breach of Contract/Fiduciary Duties ws: AND JURISDICTION t specifically under 29 U.S.C. sections
18 19 20 22 23 24 25	Plaintiff Graham Bernstein, alleges as follow NATURE OF THE ACTION 1. This case is a proceeding brought	2. Breach of Contract/Fiduciary Duties ws: AND JURISDICTION t specifically under 29 U.S.C. sections Retirement Income Security Act of

l	2.	Plaintiff files this action under 29 U.S.C. sections 502 (a) and 1004 et.
2	seq., seeking a	judicial order that certain medical benefits provided to plaintiff were and are
3	properly cover	ed/insured by defendants herein, and that defendants wrongfully withheld
4	payment there	fore and should be liable to plaintiff on behalf of the providers thereof, and,
5	further, for ent	ry of a money judgment herein for such sums as should have been paid by
6	defendants, tog	gether with interest, costs and reasonable attorneys fees.
7	3.	Plaintiff is an individual who, at the time of the activities complained of
8	herein, was liv	ing in Del Mar, California.
9	4.	The acts of defendants complained hereof herein occurred in San Diego
10	County, Califo	rnia, within this judicial district.
11	5.	Plaintiff is informed and believes and thereon alleges that defendant
12	does business	in the form of insuring and administrating health care benefits.
13	6.	The true names and capacities of defendants Doe 1 through and including
14	Doe 10 are un	known to plaintiff at this time. Accordingly, plaintiff names said defendants
15	by such fictition	ous names, and will amend this complaint to allege their true names and
16	capacities whe	on the same have been ascertained.
17		COMMON ALLEGATIONS
18	7.	Plaintiff was insured and covered through a policy and/or policies of health
19	insurance issu	ed through defendants (the "Plan" herein), and which policy and/or policies
20	were subject to	o the terms, conditions and regulations set forth in ERISA.
21	8.	Plaintiff sought medical advice and assistance from physician and surgeon
22	Dr. Michael K	halil for plaintiff's medical condition. Said physician recommended that
23	plaintiff under	go a procedure and that said procedure be conducted at Ambulatory Care
24	Surgery Cente	r (hereinafter "ACSC") Inc., in San Diego, California.
25	9.	Plaintiff thereafter accepted the advice of said physician/surgeon, and applied
26	for scheduling	of the proposed procedures through Dr. Michael Khalil, and to be performed

at the offices of ACSC.

10. 1 Plaintiff is informed and believes and thereon alleges that: 2 ACSC confirmed the availability and applicability of proper medical insurance a. 3 coverage with defendants via telephone call on October 4, 2011 with 4 Kelly at the offices of defendants at 1-800-641-7761. ACSC was advised 5 by defendants that the medical coverage provided by defendants for the 6 subject procedure would be covered at 50% of the reasonable and customary 7 charges by the clinic utilized for the procedure as an out of network provider, 8 subject to a \$6,000.00 deductible charge and a \$12,000.00 stop loss and 9 that said insurance was currently in effect, and had been in effect since 10 August 1, 2010. In that the "quote" by defendants of available insurance 11 coverage was applicable to the proposed procedure on plaintiff scheduled for 12 October 7, 2011 and was acceptable to ACSC, that entity agreed to provide the medical clinic services in question for said sum on behalf of 13 14 plaintiff. 15 b. Based upon the representations of defendants of available medical insurance 16 coverage, as outlined herein, the procedure was performed by Dr. Michael 17 Khalil on October 7, 2011, at ACSC's facility. Neither plaintiff nor ACSC would have agreed to perform the subject 18 c. 19 procedures without having been assured prior to the performance that defendants would cover and pay for the procedures and clinic costs as 20 21 outlined herein. 22 d. Thereafter, ACSC caused its billing to be sent to defendants for 23 the services provided to plaintiff on October 7, 2011, in the total sum of 24 \$16,842.28. A copy of the billing is attached hereto, marked 25 Exhibit "A", and incorporated by reference. 26 On or about November 15, 2011, defendants issued payment on medical e. 27 claim with their written "Explanation of Benefits "EOB", and sent a check to

	Case 3:12-cv-00717-AJB-JMA Document 1 Filed 03/26/12 Page 4 of 13
1	ACSC for only \$4,210.57 of provider's billing for the services
2	of October 7, 2011, declining to pay the balance which plaintiff alleges
3	defendants should have paid. A copy of the explanation of benefits
4	is attached hereto, marked Exhibit "B", and incorporated by reference.
5	f. Plaintiff and ACSC have asked defendants to pay the quoted
6	usual and customary charges but defendants have refused to do so. See
7	Exhibit "C" and incorporated by reference.
8	11. Plaintiff reasonably relied upon the representations of defendants to the
9	prospective treating clinic, as set forth above, in making the decision to proceed with the
10	above-described procedures. Plaintiff would not have allowed the procedures to take place
11	without assurance from defendants that the medical insurance through defendants and the Plan
12	would cover the costs quoted by defendants and accepted by the treating clinic. Plaintiff is
13	informed and believes and thereon alleges that defendants should have paid an additional
14	approximately \$8,421.14 on the procedure over and above the amounts defendants did pay.
15	12. The representations by defendants to ACSC were in truth and fact
16	false. Plaintiff was unaware of the falsity thereof, as was ACSC, and both plaintiff
17	and ACSC reasonably relied thereon. Accordingly, the procedures were performed
18	on plaintiff as scheduled, and defendants have not paid for that portion of the costs thereof
19	that they agreed to do.

- 13. Plaintiff is informed and believes and thereon alleges that defendants either misrepresented the nature of the available medical insurance coverage in providing the confirmation of coverage, or, alternatively, wrongfully failed and refused to honor their legal commitment to plaintiff and the treating clinic, or both.
- 14. Plaintiff is informed and believes and thereon alleges that defendants, and each of them, have engaged in a pattern of refusal to pay proper benefits in situations similar to that of plaintiff, that requests for review and/or appeal are fruitless, that defendants have failed to follow Department of Labor guidelines and/or regulations concerning the review and/or

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consideration of payments, may have improperly provided authorization for plaintiff's subject
procedure, may have improper or no claims procedures, and/or failed to maintain reasonable
claims procedures as required by 29 CFR section 2560.503.1. Further, to the extent any appeal
was made, defendants review process did not provide a reasonable and/or accurate explanation
for the decision and/or basis for the denial of the claim, further, to the extent that the subject
medical insurance contract ("Plan") between plaintiff's employer and defendants provides any
discretion to defendants, that discretion has been abused and any review of the decisions by
defendants should be undertaken by way of a de novo review. Defendants' denial of benefits
herein constitutes a breach of the Plan, violates the obligations and duties owed to plaintiff by
the defendants thereunder, and imposed by the State of California, insofar as those laws relate
to the regulation and business of insurance.

- 15. Plaintiff has been damaged in that plaintiff contractually agreed with the medical clinic provider to pay for the total of its billings for the procedure unless the charges were paid by defendant health insurance providers pursuant to the representations of said defendants to the medical clinic provider. Accordingly, plaintiff has been requested to make payment of provider's billings described above, less such portion as was paid by defendants, and has suffered damages thereby. Had defendants paid the 50% of the "usual and customary" charges made by the medical services provider as they had agreed to do in authorizing the procedure, plaintiff would have no liability other than any applicable deductible/co-insurance portion.
- 16. Pursuant to the provisions of 29 U.S.C. 1132(g)(1), plaintiff is entitled to the payment by defendants of plaintiff's actual attorneys fees incurred herein, and so demands.

FIRST CAUSE OF ACTION

FALSE PRETENSES and FALSE REPRESENTATIONS

- 17. Plaintiff refers to and incorporates by reference paragraphs 1 through and including 16, hereinabove, as though set forth at this point.
 - 18. The conduct of defendants as above-described supports a finding that defendants

1	have damaged plaintiff by committing false pretenses and/or false representations, in violation of						
2	their duties and responsibilities under ERISA.						
3							
4	SECOND CAUSE OF ACTION						
5	BREACH OF WRITTEN CONTRACT AND FIDUCIARY DUTIES						
6	19. Plaintiff refers to and incorporates by reference paragraphs 1 through and						
7	including 16, hereinabove, as though set forth fully at this point.						
8	20. Defendants, and each of them, had at all times herein mentioned an underlying						
9	written contract with the employer of plaintiff (the "Plan") to provide health care benefits						
10	pursuant to the contract between those parties, of which contract plaintiff and plaintiff's health						
11	care providers are third party creditor beneficiaries. Plaintiff does not have a copy of said written						
12	contract, but will seek to amend this complaint to provide a copy thereof when it becomes available						
13	The duties of defendants are of a fiduciary nature, are not able to be waived by defendants, and						
14	plaintiff and plaintiff's health care providers are third party creditor beneficiaries thereof.						
15	21. Under the terms of the written contract for health care benefits, as well as under						
16	the terms of ERISA, defendants agreed to act in good faith, and are required to act in good faith						
17	in the administering of health care benefits for persons covered by the terms of said contract,						
18	including plaintiff.						
19	22. Defendants have breached their contractual duties, as well as their fiduciary duties						
20	of good faith, as more fully outlined hereinabove, and thereby breached the subject written						
21	contract (the "Plan") as above-described, and are thereby in violation of the provisions of ERISA.						
22	Wherefore, Plaintiff prays for judgment as follows:						
23	A. For general damages in the sum of any and all payments which defendants should have						
24	paid under the terms of their contract (the "Plan") with plaintiff's employer, the sum of						
25	\$8421.14, more or less, according to proof;						
26	B. For interest at the maximum legal rate on such sums as are deemed owed by defendants;						
27	C. For actual attorneys fees in accordance with the ERISA Act and/or California Business &						

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1.	Professions Code, section 17200 et.seq.;
2	D. For costs of court incurred herein; and
3	E. For such other and further relief as the court may deem just and proper.
4 :	Dated: 3 22 12
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6	Kaham Benten
. 7	Graham Bernstein In Pro Per
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9	

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Exhibit B

Page 1

PO Box 10406 Van Nuys, CA 91410-0406

AMBULATORY CARE SURGICAL CENTER 5225 KEARNY VILLA WAY SAN DIEGO CA 92123-1410 COB

Process Date

Nov 15, 2011

Remittance No Payee No

V-9%

HNLF -0015633446 27-1402769 A

SVC Provider

... AMBULATORY CARE

SURGICAL

SVC Provider No. 27-1402769 A

REMITTANCE ADVICE

Patient Name

BERNSTEIN, GRAHAM

SubID SSN R05031854 XXX-XX-5876 Your Acct #

2011304-NF7-163

Claim # Receipt Date

10/11/2011 .

HEATLH NET PPO

Questions? Contact us at:

provider_services@healthnet.com or 1-800-929-9224

PO Box 10406 Van Nuys, CA 91410-0406

Svc Dates -	СРТ	Modifier 1 2 3 4	Billed Amount	Amount Not	Allowed Amount (\$)	Patient Copay Coinsurance Deductible	Total Patient Resp. Amt (\$)	Benefit Payable (\$)	Ex Code
10/07/11			16,842.28	8,421.14	8,421.14		8,421.14	4,210.57	96
						4,210.57	4,210.57		CO-INS
Total			16,842.28	8,421.14	8,421.14	4,210.57	12,631.71	4,210.57	

Member Plan Code 1AY3

Total Claims Payable

4,210.57

Total Check Amount

4,210.57

Explanation Code Description

96 -

Amount exceeds the maximum allowable for this benefit.





November 23, 2011

Health Net Appeals
Po Box10406
Van Nuvs. CA 91410-0406

Exhibit & C
Appel

Attention - Provider Appeals Unit

Patient: Graham Bernstein DOS: October 7,2011 ID#: R05031854

ID#: R050 Insured: Self

Insured. Sell

Emp: Children's specialists of San Diego

Group#: N328AA

To Appeals Department:

We are requesting an independent review of the claim for proper reimbursement for the October 7.2011 date of service for Graham Bernstein

When we called in advance of the surgery for benefits, we were informed by Health Net and we documented in writing on two separate phone calls that the benefit reimbursement for non-contracting facility providers would be 50% of usual and customary, with a \$6,000.00 deductible and a \$12,000.00 stop loss. During the phone calls we specifically asked and it was stated that the reimbursement was not based upon managed care rates with a fixed or limited fee schedule for non-contracting providers such as the \$4,210.57 payment and allowable amount of \$8,421.14. Knowingly misstating facts and policy benefits may be a violation of state courts rulings as well as a breach of the Unfair Claims Settlement Practices Acts.

The procedure, a colonoscopy with hemorrhoid banding was performed in a major operating room at our state licensed and Medicare certified surgery center in San Diego, California. The amount paid is not acceptable reimbursement considering our geographic location, procedure performed, time spent in our facility, i.e. OR, pre-op and recovery room and the itemized supplies and equipment used. The surgery center is very much aware of usual and customary rates for the San Diego area for the procedure mentioned above. The Surgery center tracks usual and customary rates for a wide variety of insurance companies and has the supporting backup data to show reasonable and customary rates in our geographical area. Your allowance of \$8,421.14 for a surgery center facility fee for the procedure mentioned above is not usual and customary. It has been shown that insurance companies use non-independent review organizations to determine usual and customary rates for out of network claims. It has also been shown that these non-independent review companies have been using inappropriately low reasonable and customary rates for out of network claims. Please have this claim reviewed by a truly external and independent review organization so that it will be paid at appropriate out of network usual and customary rates.

We would appreciate your immediate attention to this appeal, so that we may resolve this matter. We have enclosed a copy of the explanation of benefits. Please respond to us in a timely manner. Enclosed is a copy of the patient's authorization for us to appeal this claim.

Sincerely,

Billing and Collection

Case 3:12-cv-00717-AJB-JMA Document 1 Filed 03/26/12 Page 11 of 13



Health Net Life Insurance Co, P.O. Box 10406 Van Nuys, California 91410-0406 www.healthnet.com

01/11/2012

Ambulatory Care Surgical 5225 Kearny Villa Way San Diego, CA 92123 SthiBit c Dinial

Subscriber Name: Graham Bernstein Patient Name: Graham Bernstein Health Net ID #: R05031854MM1

Patient Account #: none HN Case #: 11334C00838 Claim #: 2011304-NF7-163 Date(s) of Service: 10/07/2011 Billed Amount: \$16,842.28

Dear Provider:

I am responding to your request for a claim dispute, dated 11/23/2011, regarding the above-referenced claim.

In consideration of your dispute, the following information was reviewed:

- Dispute letter dated or received on 11/30/2011
- Remittance Advice or Explanation of Benefits (EOB) issued on 11/15/2011

Based on our review of this information, Health Net's Provider Appeals Unit has determined to uphold our previous determination for the following reasons: Claim was processed based on member's out of network benefit plan at 50% of billed charges less 50% copayment.

If you believe all or part of the claim has been wrongfully denied or rejected and you have been unable to resolve your dispute with Health Net, you may have the matter reviewed by the California Department of Insurance. You may contact the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013. The Department also has a toll-free telephone number (1-800-927-HELP (4357)) and a TDD line (1-800-482-4TDD Ext. 4833) for the hearing and speech impaired. The Department's Internet website is www.insurance.ca.gov. Out of state members may call 1-213-897-8921.

Billing Dispute External Review Board (BDERB)

You have now exhausted Health Net's internal review process for the subject claim(s). Health Net contracts with Independent Medical Expert Consulting Services, Inc (IMEDECS) to perform Billing Dispute External Reviews of qualifying disputes. To learn more about the process, or determine if your claim qualifies for BDERB, please visit Health Net's website at www.healthnet.com.

If you should have any additional questions or concerns, please contact our Provider Services Department at (800) 641-7761. Provider Service Department Representatives are available Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

Sincerely, Adelle J. Provider Appeals Unit 21S 44 (Rev. 12-07)

CIVIL COVER SHEET

The IS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Corker of the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

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160 Stockholders', Suits		Property Damage		362 Black Lung (923)	875 Customer Challenge
190 Other Contract	Product Liability 3, 385	Property Damage		© 863 DIWC/DIWW (405(g))	12 USC 3410
195 Contract Product Liability 17 196 Franchise	Injury	Product Liability		☐ 864 SSID Title XVI ☐ 865 RSI (405(g))	R90 Other Statutory Actions R91 Agricultural Acts
REAL PROPERTY		ONER PETITIONS	O 740 Railway Labor Act	FEDERAL TAX SUITS	□ 892 Economic Stabilization Act
210 Land Condemnation		Motions to Vacate	790 Other Labor Litigation	870 Taxes (U.S. Plaintiff	☐ 893 Environmental Matters
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VII. REQUESTED IN		LASS ACTION	DEMANDS 100		if demanded in complaint:
COMPLAINT:	UNDER F.R.C.P. 23	Sign.	- 8421	JURY DEMAND:	Yes O No
VIII. RELACTOR			蘇密特灣大學工作學	and the second second	
IF AND E	C Care il trul (ns)	n de la companya de l		DOCKET NUMBER	
	\mathcal{N}/\mathcal{M}	(34) <u>- 134</u>	Tak Tari Taka I Sa	_	
DATE 12 /	77	NATURE OF ATTO	RNEY OF RECORD.		^
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	RN DISTRICT OF CALIFORNIA	PLYING IFP	JUDGE	MAG, JUI	OGE 1
RY (1)	FRO OF CALABOTEPUTY	,]			

Court Name: USDC California Southern

Division: 3

Receipt Number: CAS036822 Cashier ID: nsiefken

Transaction Date: 03/26/2012 Payer Name: WALK-UP CUSTOMER

CIVIL FILING FEE

For: WALK-UP CUSTOMER

Case/Party: D-CAS-3-11-CV-000717-001

Amount: \$350.00 -----

CHECK

Check/Money Order Num: 1363 Amt Tendered: \$350.00

Total Due:

\$350.00

Total Tendered: \$350.00

Change Amt: \$0.00

There will be a fee of \$53.00 charged for any returned check.